

471-000-95 Instructions for Completing Form MC-73, "Time Assessment and Service Plan"

Use: Form MC-73, "Time Assessment and Service Plan," is completed by local office staff with the client during an interview to determine eligibility for personal assistance services. The Social Services Worker or designee must interview the client and/or guardian by telephone or in person. The client and/or guardian must be an integral part of the development of the assessment and service plan by stating their service needs and preferences, and jointly determining the time to be authorized.

Completion: Local office staff completes all sections of Form MC-73 as follows:

Section I

Enter the client's name, Medicaid number, guardian's name (if applicable), and contact information.

Section II

Check all eligibility criteria that apply. All must be checked for client to be eligible for Personal Assistance Services (PAS).

Section III

1. Determine the client's specific needs for PAS by asking the client and/or guardian to identify the tasks.
2. Ask the client and/or guardian about other services being received.
3. Utilizing the list of specific tasks identified, and together with the client and/or guardian, determine the time each activity will reasonably require.
4. Specialized Procedures require Form MILTC-4D for health maintenance activities.
5. Supportive Services may be added only as a supplement, not as the only category of services being provided
6. Determine the total amount of time to be authorized for PAS based on the joint determination of needed tasks and time required.

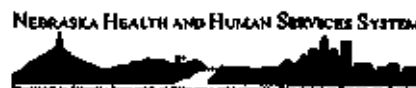
Section IV

1. Together with the client and/or guardian, discuss the client's preference for a provider. If there is a preference of provider(s), include the name(s) on the service plan.
2. Suggest the client and/or guardian have arrangements for an alternative provider for emergencies.
3. Form MC-73 is signed by the Social Services Worker or designee and the client or guardian. If the interview is by telephone, the form is mailed for his/her signature.

Distribution: Local office staff retains the white original of Form MC-73. The client receives a yellow copy and the provider receives a pink copy.

Retention: The local office staff retains Form MC-73 as a permanent part of the client's case record.

TIME ASSESSMENT AND SERVICE PLAN



SECTION I:

Client:	Medicaid#:
Guardian (if applicable):	
Contact Information:	

SECTION II: Check all that apply. All must be checked for client to be eligible for Personal Assistance Service (PAS).

- ☐ 1. Is a current Medicaid client;
- ☐ 2. Needs personal assistance services to live in the community;
- ☐ 3. Does not have needs that require more intensive services due to an acute health care level;
- ☐ 4. Is not receiving or eligible for PAS or similar support based on residence or place of employment;
- ☐ 5. Lives in a residence not a hospital, nursing facility, intermediate care facility, prison, or other institution.

SECTION III: Discuss with client/guardian the needs for assistance and indicate the time needed for each task. Include explanation of any other services currently being provided to meet the needs in the area under "Special Instructions/Comments". Also use "Special Instructions/Comments" to explain why additional time is needed beyond the estimated time frames. Please consider that some tasks may be completed at the same time.

Personal Assistance Service Needs	Estimated Time	Time Needed	Special Instructions/Comments
Nutrition <input type="checkbox"/> Needs meals prepared ____x/day <input type="checkbox"/> Needs assistance with meal prep ____x/day <input type="checkbox"/> Needs reminding to eat <input type="checkbox"/> Needs assistance with eating such as cutting meal ____x/day <input type="checkbox"/> Needs to be fed ____x/day <input type="checkbox"/> Needs meals prepared ____x/day <input type="checkbox"/> Special diet <input type="checkbox"/> Other	15-30 minutes 5 minutes 15-30 minutes 1 hour		
Grooming/Hygiene <input type="checkbox"/> Bath/shower ____x/wk <input type="checkbox"/> Dressing ____x/day <input type="checkbox"/> Shampoo ____x/wk <input type="checkbox"/> Shaving ____x/wk <input type="checkbox"/> Hair grooming ____x/wk <input type="checkbox"/> Oral care ____x/day <input type="checkbox"/> Nail care ____x/day <input type="checkbox"/> Assist w/TED Hose <input type="checkbox"/> Other	15-30 minutes 15-20 minutes 30-60 minutes 10 minutes 5 minutes 10 minutes 10-15 minutes		
Mobility Transfer: <input type="checkbox"/> Minimal Assistance <input type="checkbox"/> Moderate Assistance <input type="checkbox"/> Heavy Support/Lifting <input type="checkbox"/> Special Assistive Devices(specify) <input type="checkbox"/> Turn and Position in Bed Walking: <input type="checkbox"/> Minimal Assistance <input type="checkbox"/> Moderate Assistance <input type="checkbox"/> Heavy Support/Lifting <input type="checkbox"/> Special Assistive Devices(specify) Wheelchair Maneuvering: <input type="checkbox"/> Partial Assistance <input type="checkbox"/> Complete Assistance <input type="checkbox"/> Other	15-30 minutes 5-10 minutes 5 minutes 10 minutes up to 15 minutes each		



Toileting/Bowel and Bladder Care <input type="checkbox"/> Assist on/off toilet <input type="checkbox"/> Cleansing on toilet <input type="checkbox"/> Establish/maintain brief/diaper/bedpan routine <input type="checkbox"/> Change/empty catheter bag <input type="checkbox"/> Other	15-30 minutes		
Medications <input type="checkbox"/> Assist with administration of medications <input type="checkbox"/> Remind to refill prescriptions <input type="checkbox"/> Other	5 minutes per task		
Specialized Procedures (health maintenance activities) <input type="checkbox"/> Administration of injections _____ x/day <input type="checkbox"/> Insertion of catheter _____ x/day <input type="checkbox"/> Administration of oxygen _____ x/day <input type="checkbox"/> Wound irrigation _____ x/day <input type="checkbox"/> Application of dressings _____ x/day <input type="checkbox"/> Check vital signs _____ x/day <input type="checkbox"/> Other	5-10 minutes 15-30 minutes 15-30 minutes 15-30 minutes 30 minutes 15 minutes		<input type="checkbox"/> Physician/RN Statement signed
Supportive Services <input type="checkbox"/> Laundry _____ x/wk Clean <input type="checkbox"/> bathroom _____ x/wk <input type="checkbox"/> kitchen _____ x/wk <input type="checkbox"/> other living areas used by client _____ x/wk <input type="checkbox"/> Make bed &/or change linens _____ x/wk <input type="checkbox"/> Wash dishes _____ x/wk <input type="checkbox"/> Remove trash _____ x/wk <input type="checkbox"/> Shopping for groceries _____ x/wk <input type="checkbox"/> Shopping for personal items, medications and other _____ x/wk <input type="checkbox"/> Accompanying to appointments _____ x/wk <input type="checkbox"/> Other	2 hours per week 30 minutes 15 minutes 15 minutes 5-10 minutes 10-15 minutes 5 minutes 1-3 hours/week 1/2 hour 1-3 hours		
TOTAL TIME*			

*Prior authorization from Central Office is needed if total time will exceed 40 hours per week.

Section IV: Does the client have a preferred provider who is willing to provide the service? _____ Yes _____ No

Name: _____
 Address: _____
 Phone: _____

If so, is the provider already approved? _____ Yes _____ No

Completed by: _____
 Social Services Worker(or designee) Date Client Date

Distribution: WHITE COPY - Local Office; YELLOW COPY - Recipient; PINK COPY - Provider